

General

Guideline Title

Practice parameter for cultural competence in child and adolescent psychiatric practice.

Bibliographic Source(s)

Pumariaga AJ, Rothe E, Mian A, Carlisle L, Toppelberg C, Harris T, Gogineni RR, Webb S, Smith J, American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter for cultural competence in child and adolescent psychiatric practice. *J Am Acad Child Adolesc Psychiatry*. 2013 Oct;52(10):1101-15. [104 references] [PubMed](#)

Guideline Status

This is the current release of the guideline.

Recommendations

Major Recommendations

Principle 1. Clinicians should identify and address barriers (economic, geographic, insurance, cultural beliefs, stigma, etc.) that may prevent culturally diverse children and their families from obtaining mental health services.

Non-Hispanic white families are twice as likely as minority families to seek mental health treatment for their children despite evidence suggesting the prevalence of psychiatric disorders in children does not appear to vary greatly by race or ethnicity. When minorities seek treatment, they may not remain engaged in outpatient services or use as many service units. Multiple systemic and logistical barriers that interfere with timely access to services are disproportionately experienced by racially/ethnically diverse families. These include financial needs, location of services and transportation, lack of adequate insurance, poorly understood bureaucratic procedures, and lack of linguistic support. Even when minority children and families receive services, these are often interrupted prematurely by these barriers.

Stigma can be a powerful barrier to timely access to treatment. In many cultures, mental illness has major negative connotations, leading to the fear of double discrimination (as a result of being culturally different and perceived as "crazy"), which prevents minority families from accessing services. These perceptions can then become self-reinforcing when emergency services are needed owing to the traumatic impact of suddenly receiving a more restrictive level of care and/or their involuntary nature. Families may mistrust mental health service agencies given their histories of discrimination and disregard for cultural needs. Culturally diverse families are more vulnerable to perceived or actual power differentials in their encounters with health care professionals.

Diverse families should be educated to improve their understanding of diagnosis and treatment, empower decision making, expose myths, and improve treatment outcomes. Clinicians should address the realities and perceptions of power differentials that may interfere with therapeutic relationships.

It is not uncommon for minority children and adolescents to engage in mental health treatment for troubling behaviors identified by the school or the

court, rather than by their parents. One explanation is that minority families tend to have a higher threshold for disruptive behaviors and to not seek professional intervention until the situation becomes unmanageable.

Principle 2. Clinicians should conduct the evaluation in the language in which the child and family are proficient.

Language-based communication is critical in obtaining accurate clinical information and establishing a therapeutic alliance. Many immigrants, however, are not fluent in English and thus may be unable to fully participate in the clinical process. In these situations, translation and interpretation are critical to effective care. Limited English proficiency is a significant barrier to accessing mental health services for adults and children from different ethnic origins, resulting in significantly lower utilization of mental health services. Lack of appropriate linguistic ability or interpreter support has been associated with misdiagnosis and adverse clinical outcomes. In these cases, clinicians should obtain linguistic support through qualified interpreters or possess demonstrable proficiency in the target language. Unfortunately, translation and interpretation are often considered menial or informal tasks in the clinical process, as reflected by using untrained interpreters or translators without regard to impact on family relations, family members, siblings, or the child. Language brokering, the common practice of having children act as interpreters between parents and medical and school authorities, should be avoided, particularly when the patient is the language broker. An association has been identified between high language-brokering contexts and higher levels of family stress, lower parenting effectiveness, poorer adjustment in academic functioning, higher Child Behavior Checklist internalizing scores, and substance use in adolescents. Telephonic interpretation services enable 24-hour access and a wide range of available languages but are not ideal owing to their lack of ability to convey nonverbal communication. Interpreters should have proper training in the skill of interpretation and the content area being discussed. They should serve as integral members of the clinical team, serve as cultural consultants when they have understanding of the family's culture, and interpret all verbal, nonverbal, and implicit communications from the child and family rather than provide summaries. If live translation services are not available, clinicians may have to use alternatives (telephonic interpreter services, individuals with dual-language abilities, or someone the family or child identifies), but efforts should be made to obtain the consent of the individuals using written or nonverbal means. Any educational materials and rating or diagnostic instruments should be translated to the language of the family member or child, and their reliability and validity in the target cultural group should be established using well-accepted reverse translation and psychometric methodologies. In the event materials or instruments have not been formally translated or validated, practitioners should access translation services from trained professionals or from bilingual child mental health professionals. Clinicians should be cautious about clinical interpretations based on diagnostic instruments not properly translated or validated with the population in question.

Principle 3. Clinicians should understand the impact of dual-language competence on the child's adaptation and functioning.

An estimated 20% of American children 18 years and younger grow up exposed to 2 languages. Learners of English as a "second language" (defined as any language learned after 3 years of age, which is the end of the critical period for rapid language acquisition) constitute the majority of dual-language children in America. After English, the most common home language in the United States is Spanish. Grammatical and other language errors made by a child learning a second language (or a second English dialect, such as standard American English for a speaker of Black English) should not be confused with the grammatical or lexical abnormalities of language disorders. In contrast, deficits associated with psychiatric and language disorders (such as auditory-verbal working memory deficits) may slow the acquisition of a second language. Specialized consultation and assessment over time by a speech/language pathologist with expertise in dual-language children may be necessary to differentiate normal from disordered language acquisition.

There is evidence that maintaining the first (home) language is important in accessing family and community protective factors and other benefits. Despite this evidence, there has been a poorly substantiated practice of recommending to parents that they discontinue speaking the home language to a child who is facing language, cognitive, or other delays. This practice has little or no empirical support, and the limited research conducted in this area suggests that children with language impairment can be healthily exposed to and learn 2 languages with no significant detrimental effects. Although it may be true that certain children with linguistic or other deficits may become overwhelmed by the additional cognitive and linguistic demands of dual-language learning, recommendations to discontinue learning the home language may have potentially serious consequences and should not be made lightly. Rather, such decisions should ideally involve full assessment by a speech/language pathologist with appropriate expertise, consultation with the parents and others who know the child well, and an informed decision process by the parents with consideration of the family's plans for the future. For example, a child whose family speaks only a minority language may need to maintain and learn that language.

Sudden language immersion may be stressful, depending on the child's temperament and availability of supports. Children who are suddenly immersed in a second language environment with no knowledge of the language may go through a normal "nonverbal period." This should not be confused with selective mutism, which has a higher prevalence among immigrant dual-language children. Thus, it is important that clinicians be familiar with features that differentiate the normal nonverbal period from selective mutism, which typically lasts much longer.

Principle 4. Clinicians should be cognizant that cultural biases might interfere with their clinical judgment and work toward addressing these biases.

Adult and pediatric psychiatry literatures provide evidence for cultural and racial disparities in diagnostic assessment, treatment measures, and quality of received health care. Stereotyping, biases, and uncertainties in health care providers can lead to unequal treatment. When the patient's

presentation or diagnosis is unclear, physicians may inadvertently over-rely on behavioral or clinical stereotypes of specific groups at the expense of focusing on the patient's unique experience, clinical presentation, or sociocultural context.

Principle 5. Clinicians should apply knowledge of cultural differences in developmental progression, idiomatic expressions of distress, and symptomatic presentation for different disorders to the clinical formulation and diagnosis.

Motor, language, cognitive, and social development appear to differ across cultures. These differences may result from developmental expectations consistent with differentiated cultural value systems. Such differences, seen out of cultural context, could lead to the misidentification of pathology or misdiagnosis of mental disorders. Expressions for psychological or emotional distress also differ across cultures. Idioms of distress are linguistic or somatic patterns of experiencing and expressing illness, affliction, or general stress. Idioms of distress do not generally correspond to diagnostic categories. They can at times be an alternative means of expression for disorders recognized by Western psychiatry, such as depression or anxiety disorders. However, they can just as easily be expressions of psychological distress unique to a given culture or even common normative expressions of stress. More complex expressions of illness or distress are termed *cultural syndromes*. Idioms of distress and cultural syndromes can often be mistaken for more serious psychopathology, although they are often normal variants of expression of distress.

Common patterns of symptomatology displayed by children from diverse populations can differ significantly from those in Euro-Americans due in part to the influence of their culture. For example, in minority youth, somatization and anger are frequently associated with depression and anxiety, and psychosis is often overdiagnosed. Emotional reactivity during depression is greater in Asian-origin individuals than in whites.

In the evaluation of children from less assimilated families, it is critical to recognize cultural manifestations of distress or illness, such as cultural syndromes. Accurate assessment can prevent misdiagnosis and erroneous treatment. It is important to seek consultation from a colleague with cultural expertise on the cultural context and the significance of particular idiomatic expressions or symptoms that may be culturally influenced.

The *Diagnostic and Statistical Manual of Mental Disorders (DSM)* Outline for Cultural Formulation has provided a useful framework for assessing sociocultural aspects of the patient's mental health and relating these to the clinical formulation. The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* provides a revised version that calls for systematic assessment of 5 distinct categories: *cultural identity of the individual*, consisting of the individual's racial, ethnic, or cultural reference groups and other relevant aspects of identity, such as degree of involvement with the culture of origin versus host culture, religion, socioeconomic background, place of origin, migrant background, and sexual orientation; *cultural conceptualization of illness*, including the influence of cultural beliefs on the individual's experience, conceptualization, and expression of symptoms or problems; *psychosocial stressors* and *cultural features of vulnerability and resilience*, including key stressors and supports in the individual's sociocultural environment (such as religion, family, and social supports); *cultural features of the relationship between the individual and the clinician*, such as dynamics of differences based on cultural, socioeconomic, language, and social status that may cause differences in communication and influence diagnosis and treatment; and *overall cultural assessment* summarizing the implications of these aspects for diagnosis, plan of care, and other clinically relevant issues.

The *DSM-5* also includes the Cultural Formulation Interview (CFI), a 16-item semistructured interview to obtain information about the impact of culture on clinical presentation and care, with suggested questions to inquire about different domains. The CFI contains 4 assessment domains: cultural definition of the problem; cultural perceptions of cause, context, and support; cultural factors affecting self-coping and past help seeking; and cultural factors affecting current help seeking. The CFI also includes Supplementary Modules as adjuncts to the core CFI that provide more in-depth assessment of various areas. The CFI was field tested for diagnostic utility among clinicians and acceptability among patients as part of the DSM field trials, although the trials did not include children and youth.

An important reference for cultural differences in developmental progression, expressions of distress, and symptomatic presentation by gay, lesbian, and transgendered youth, and how these affect their assessment and treatment can be found in the AACAP Practice Parameter for gay, lesbian, and transgendered youth.

Principle 6. Clinicians should assess for a history of immigration-related loss or trauma and community trauma (violence, abuse) in the child and family and address these concerns in treatment.

Migration has risks and stressors unique to immigrants. These can be divided into premigration stress, such as exposure to violence, persecution, and torture in the country of origin; migration stress, including the disruption and separation of families, traumatic journeys, detention in refugee camps, and various forms of victimization, such as abuse by smugglers; and postmigration and acculturation stress, resulting from low levels of education and job skills, living in high-risk neighborhoods, with high exposure to crime and violence, and overcrowded, poor-quality inner-city schools. In addition, immigrant children and their families often face the stressors of prejudice and discrimination against immigrants and those experienced by nonimmigrant minorities, especially if racially different from the majority culture, which may lead to poor academic functioning, low self-esteem, depression, and suicide. Some minority youth adopt a position of defiance against the dominant culture by joining gangs. As a result of these stressors, second-generation children of immigrants are generally at increased risk for mental health problems, including anxiety, depression, substance abuse, and posttraumatic stress disorder (PTSD). The stresses of immigration on the family also can result in domestic violence and

criminal activity. Factors such as parental emotional well-being and peer relationships can mitigate or aggravate these problems.

Immigration to the United States can lead to complex patterns of family fragmentation and reunification. To become established, parents may immigrate before their children, leaving them with relatives in the country of origin. Children are often brought to the United States years later with hopes of offering them a better education and future. Children are often torn away from grandparents and other extended family members who have become their primary caregivers, often with little recognition of the mourning process involved. Parents can become dismayed and disappointed with the unhappiness, even rejection, their estranged children may demonstrate toward them. Children who have experienced such separations or losses have a higher risk for later developing depression, conduct disorder, and substance abuse disorders compared to other immigrant children. Adolescent victims of war and genocide have elevated rates of conduct disorder, aggressive and sexual acting-out behaviors, substance abuse, depression, and PTSD. Those exposed to traumatic crossings and confinement in refugee camps experienced silent symptoms of PTSD, which often went unnoticed by teachers. Treatment of immigrant and refugee children and inner-city minority children must address traumatic exposure from these various sources, use evidence-based interventions that address the impact of trauma in the child and family, and provide for community support.

Principle 7. Clinicians should evaluate and address in treatment the acculturation level and presence of acculturation stress and intergenerational acculturation family conflict in diverse children and families.

Acculturation directly affects the developmental task of identity, just as racial/ethnic identity constitutes a significant aspect of psychological identity. Peers and family members serve as "mirrors" against which the self is reflected. For racially/ethnically diverse children and youth, this mirroring comes from 2 sources: the traditional cultural environment of the home and the mainstream cultural environment of peers, school, and the broader community, which can result in conflicting images. Diverse children and youth often face significant pressures to assimilate into mainstream society through media images and implicit threats of social and economic marginalization. In the process of acculturation, research supports that the best adaptational outcomes for youth are associated with the development of a *bicultural identity*, in which the immigrant youth remain rooted in their culture of origin (often mediated by learning the home language) but have the necessary knowledge and interpersonal skills to successfully navigate mainstream culture (i.e., a hyphenated identity). However, immigrant children and families face other potential outcomes: *marginalization*, with separation from the 2 cultures and some degree of ethnic identity diffusion; *assimilation*, in which the culture of origin is rejected and the host culture is largely adopted, with the loss of language and customs of origin; *separation*, in which the host culture is rejected and there is a strong adherence to the traditional culture and language, often remaining bound to the "ethnic enclave"; and negative identification, a form of marginalization in which the youth is openly hostile to the 2 cultures and adopts values and practices antithetical to both (e.g., adoption of gang culture).

Acculturation stress is the distress and internal conflict resulting from adaptation to a new host culture, including internal cultural value conflicts and external pressures to assimilate, and facing the host society's hostility in the form of racism and discrimination. It also can result from the loss of protective aspects of the traditional culture that help with developmental stresses (e.g., religious prohibition against suicide) while not yet adopting those from the host culture. Acculturation stress can increase risk for psychopathology including substance abuse, depression, anxiety, suicidality, conduct disturbance, and PTSD. It also can aggravate pre-existing conditions.

Many immigrant families are headed by parents with traditional cultural beliefs, who are experiencing the process of acculturation themselves but without their children's cognitive, linguistic, or emotional flexibility. Differences in acculturation between parents and children can lead to intergenerational acculturation conflict, which may result in psychological distress. Such acculturation discrepancies are most prominent during adolescence. One factor that may contribute to acculturation conflicts is the assumption of a parentified role by a more assimilated immigrant child as a means of assisting their less assimilated parents to navigate the new cultural milieu of language, rules, and norms. Although parentification can be adaptive, it can represent an inversion in family roles and authority if maintained over time and contribute to heightened intergenerational conflict when parents attempt to assert their authority.

Differential acculturation between immigrant parents and their children leads to incongruence of values and expectations, resulting in intergenerational conflict and distancing. In some Asian American families, differential acculturation is a predictor of negative mental health consequences for youth, such as school difficulties, gang involvement, depression, and suicidality. In Hispanic families, orientation to mainstream American culture, when coupled with the retention of Hispanic cultural practices and heritage, is associated with positive adjustment outcomes in youth, such as the absence of conduct disorders and substance abuse. Increased parental involvement, positive parenting, promoting biculturalism in Hispanic adolescents and their families, and reframing intergenerational difficulties as culturally based disagreements have been efficacious in improving family functioning and adolescent behavior problems.

Acculturation stress, intergenerational acculturation conflict, and interventions designed to address them should be routine in the assessment and treatment of children of immigrants or minority families. Interventions aimed at enhancing minority adolescents' mental health should focus on the intergenerational relationship, because it is a predictor of the youths' outcome. Family-based intervention, where intergenerational and intercultural conflict is explored and the value of communication within cultural expectations is underscored, is effective when working with adolescents.

Principle 8. Clinicians should make special efforts to include family members and key members of traditional extended families, such as grandparents or other elders, in assessment, treatment planning, and treatment.

In collectivist cultures, in which people view themselves primarily as members of groups and usually consider the needs of the group over the needs of individuals, extended family involvement may be the only acceptable model of addressing emotional and mental health problems. In contrast, in individualistic cultures, these problems are addressed by the individual or immediate relatives. Therapeutic engagement of diverse families may call for strategies not used in individualistic cultures. Involvement of extended family members and non-blood relatives with an equivalent emotional bond (i.e., "fictive kin") is important in obtaining necessary collateral input for appropriate diagnosis, subsequent treatment recommendations, and treatment adherence. Although clearly beneficial, this extended involvement may raise challenging issues of confidentiality. Confidentiality should be maintained in such a manner that it does not interfere with communication and collaboration. Clinicians should explain the importance of confidentiality in psychotherapy to the family, so they are not perceived as "driving a wedge" between the child and the family or used by the patient to resist dealing with family issues. However, family conflict often predicts the use of mental health services for diverse patients, so it is important that clinicians ascertain whom the patient considers family and determine if they are a source of stress or support.

The mental health literature has explored the potential impact of culture on boundary-keeping practices (i.e., the maintenance of parameters that individuals or societies use to define interpersonal and professional boundaries). People from collectivist backgrounds view concepts that define such boundaries, such as time, confidentiality, dual relationships, and self-disclosure, differently than those from individualistic cultures. These differences can affect the therapeutic process. It is recommended that clinicians carefully negotiate boundaries and treatment parameters with culturally diverse patients and families. During negotiation, the providers should respect culturally established means of communication and family role functioning, but also foster family flexibility in dealing with their bicultural offspring around such issues. This process establishes a collaborative process involving the mental health provider and the family.

Accurate, valid consent forms translated into the patient's and family's primary languages and interpreter services are essential (see Principle 2 above). It may be important to allow the family extra time to consult traditional and family decision makers in their consent process. These decision makers have major influence in the family consent process. Actively avoiding their input can result in significant problems with treatment adherence. An overly paternalistic style on the clinician's part may lead a patient to not return or politely agree to the plan but then not adhere. The use of family psychoeducation is critical to addressing questions and culturally based myths and misconceptions about psychiatric medications, including the rationale for their use, mechanism of action, and benefits versus risks for the child. Diverse families often have a background of limited treatment options and decision-making opportunities. Thus, it is especially important to assist them in developing knowledge and skills to address their child's mental illness, questioning perceived authority, and exercising their rights for second opinions or alternative treatment resources.

Principle 9. Clinicians should evaluate and incorporate cultural strengths (including values, beliefs, and attitudes) in their treatment interventions to enhance the child's and family's participation in treatment and its effectiveness.

Clinicians should assume a posture of genuine cultural curiosity in learning about the family's traditional cultural beliefs/values. A culturally competent approach promotes the incorporation of beliefs, values, attitudes, and cultural rituals and practices within mental health treatment, using psychoeducational approaches to bridge traditional understanding of illness and its treatment, with Western conceptualizations and its medical/scientific model. The process of participatory or shared decision making, where cultural aspects are integrated into the implementation of evidence-based practice, is crucial to enhance culturally competent care that ensures treatment engagement. Many culturally competent psychotherapeutic approaches and interventions have been developed, including storytelling and cultural themes, symbolic rites of passage, and matching therapists according to their racial/ethnic background.

Culturally adapted treatment modalities may have some improved effectiveness compared with standard interventions, although the evidence is mixed.

Diverse cultural groups' explanatory models for mental health and illness can vary, invoking spiritual, supernatural, sociologic, and interpersonal explanatory models. Such explanatory models often lead families to seek help for their children's problems from a spiritual healer, church elder, community leader, or relative, rather than from mental health professionals. Reasons for such preferences include greater acceptability of the healer's explanatory model of illness, greater family support, less stigma for seeking services, and perceived greater rapidity and effectiveness. This preference is seen particularly among first-generation immigrants and refugees, including Latinos, Asian-origin, American Indian, and some European-origin groups.

Clinicians should consider consulting and collaborating with traditional healers (e.g., *curanderos*, *santeros*, or shamans) and including rituals and ceremonies in psychotherapy with children from more traditional backgrounds. Collaboration with indigenous traditional healers can ameliorate cultural loyalty conflicts within families and children and improve access to care in populations unfamiliar with or even mistrusting of the medical/psychiatric model. This is typically feasible when traditional healing methods complement or enhance (and do not directly conflict with) the effectiveness of Western psychotherapeutic and pharmacologic interventions. Traditional healers are often reticent to identify themselves as

collaborating with Western-trained clinicians. However, mutual respect and education in exchanging information and perspectives can foster collaboration.

Principle 10. Clinicians should treat culturally diverse children and their families in familiar settings within their communities whenever possible.

Diverse children and families often prefer ethnically specific community clinics or clinics located within schools or ethnic neighborhoods. School-based services are also generally well accepted and highly effective.

Clinicians should favor home- or community-based alternatives to hospitalization for minority children owing to the integral nature of community and family to their identity and emotional supports. Any out-of-home placement or hospitalization should ideally be accomplished with family and youth cooperation. The principles of treatment in the least restrictive environment are especially important given how some treatments may remove youth from their community, extended family, and traditional cultural supports. Involuntary hospitalization should be avoided because it tends to re-exacerbate past traumas, contribute to new ones, and reawaken historic mistrust of the mental health system. Psychiatrically hospitalized African American youth have a significantly greater tendency to be admitted involuntarily, which enhances such fears and mistrust.

The cultural competence model and the principles of community systems of care promote the use of community resources and cultural strengths to facilitate effective interventions with diverse children and youth, reinforcing adaptive cultural values and beliefs. Systems-of-care programs have some demonstrated effectiveness in improving access to care and improving outcomes for diverse children and youth.

Principle 11. Clinicians should support parents to develop appropriate behavioral management skills consonant with their cultural values and beliefs.

Culturally diverse parents tend to accept and adhere more to behavioral management skills when these are consonant with their culture.

Clinicians should advise families about parenting approaches that may be incongruent with Western culture, especially approaches that are illegal. It is also important to address parent-child boundary issues that may become problematic with the child's increasing acculturation.

Principle 12. Clinicians should preferentially use evidence-based psychological and pharmacologic interventions specific for the ethnic/racial population of the child and family they are serving.

It is incumbent on clinicians to preferentially use evidence-based interventions with specific population-based evidence. Psychotherapeutic interventions demonstrating evidence with diverse populations include cognitive-behavioral therapy for treatment of depression in Latinos and African Americans, interpersonal psychotherapy for treatment of depression in Latinos, cognitive-behavioral therapy for treatment of anxiety disorders in Latinos, group cognitive-behavioral therapy for anxiety disorders in African Americans, trauma-focused cognitive psychotherapy and peer-mediated treatment for traumatic stress for African Americans, and manualized family therapy for the treatment of substance abuse for Latinos. Most of these studies have involved culturally adapted protocols. Community-based interventions with racial-/ethnic-specific evidence include multisystemic therapy for conduct disturbances, substance abuse, and suicidality in African Americans, Asian Pacific Islanders, and Latinos; school-based cognitive-behavioral interventions for treatment of depression in African Americans and Latinos; and school-based cognitive-behavioral interventions for trauma in Latinos. Many evidence-based interventions have been evaluated with African American and Latino youth with conduct problems, with more than a dozen of these distinct treatments having been successfully tested in randomized trials.

Relatively less evidence exists for pharmacologic interventions; however, some data are available for diverse populations. See the original guideline document for more information.

Principle 13. Clinicians should identify ethnopharmacologic factors (pharmacogenomic, dietary, use of herbal cures) that may influence the child's response to medications or experience of side effects.

It is important to avoid the harmful stereotyping around race and genetics of the past and to adopt a new approach to the consideration of biological and genetic factors that serves the goal of addressing health disparities. Although most genetic variation is shared worldwide, the relative proportion of functional genetic variants for any given gene may vary by ancestry. This in theory can lead to different patterns of medication metabolism and activity and risk for side effects. Ethnopsychopharmacology has focused on the study of pharmacogenomic risk alleles that vary in frequency across different ethnic and racial populations, raising questions about the importance of these factors in prescribing. These include the distribution of rapid, slow, and super-slow activity of cytochrome P450 (CYP) isoenzymes (especially CYP2D6 and CYP2D19) across different racial and ethnic populations and polymorphisms of the serotonin 2A and dopamine D3 receptors related to antipsychotic and antidepressant treatment response. These differences have been associated with reports of African Americans (and Caribbean Latinos with African heritage) experiencing lesser response to serotonin reuptake inhibitors and more frequent extrapyramidal side effects with antipsychotics, and Asians having a larger percentage of slow metabolizers and often experiencing Western medicines as being "too strong" with many side effects.

Despite extensive pharmacogenomic research, there are few identified genetic variants with definitive clinical utility. There is a vast number of genes

involved in medication response and metabolism, particularly for drugs with central nervous system (CNS) activity. Much of the focus to date has been on the effects of genes on enzymes responsible for phase I metabolism (e.g., CYP enzymes), receptor regulation, and receptor transporters. Genetic variants within these classes of genes have been variably associated with differential treatment response and side effect profiles. However, the effect sizes are small, and the specific risk variants are often not consistently replicated in other studies.

Using race or ethnicity as a solitary marker for specific pharmacogenomic profiles raises some confounds. The human genome is enormously complex, the predominance of genetic variation in the human genome is shared across all human populations, yet individuals are genetically unique. Alleles that vary widely in frequency across different human populations often have no functional significance. Alleles with widely varying frequencies based on ancestry also are prone toward false positive findings in genetic association studies, a phenomenon known as population stratification. In addition, racial intermixing in modern populations renders generalizations around genetics meaningless.

Gene-by-environment interactions are also important in predicting medication response and further complicate the use of race or ethnicity as a simple pharmacogenomic predictor. For example, grapefruit juice may increase serum concentrations of nefazodone and alprazolam by affecting the CYP3A4 isoenzymes and corn diets may increase serum concentrations of selective serotonin reuptake inhibitors by affecting CYP2D6 isoenzymes. Thus, the dietary practices of different cultural groups need to be considered when prescribing. Such practices may change as individuals migrate to different regions and adopt the practices of their new community. In addition, findings of interactions between stressful life events and genetic polymorphisms in serotonin transporter genes in the expression of major depression may present even greater confounds for minority and underserved populations chronically exposed to such stress.

Thus, at this time, although there is great promise for pharmacogenomics to advance personalized medicine, further research is needed to identify genetic factors with definitive impact on treatment response and side effect profiles. Until such findings are available, clinicians should exercise caution in prescribing and dosing psychopharmacologic agents for diverse patients. They should base decisions on the individual's clinical and familial histories, migration and ancestral histories, personal and familial histories of pharmacologic response, and dietary history. Currently available pharmacogenomic testing may have some limited utility in cases of diverse children with mixed racial/ethnic background and atypical pharmacologic response.

It is important that clinicians inquire about and discuss the use of alternative medicinal and herbal remedies by culturally diverse youth and families. Western medicine has not eclipsed traditional medicine, and the 2 are often practiced simultaneously or sequentially. Herbs and other traditional remedies sometimes have strong active ingredients, such as atropinic substances that can produce anticholinergic side effects and even toxicity. Many patients and families do not inform their doctor they are consuming these substances unless asked directly. When these do not pose any adverse interaction or might even be beneficial, clinician acceptance of their use can help to build the therapeutic alliance and acceptance of Western therapeutic approaches.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Any psychiatric condition as it relates to cultural and racial factors

Guideline Category

Counseling

Diagnosis

Evaluation

Management

Risk Assessment

Treatment

Clinical Specialty

Pediatrics

Psychiatry

Psychology

Speech-Language Pathology

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Nurses

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Social Workers

Speech-Language Pathologists

Guideline Objective(s)

To outline clinical applications of the principle of cultural competence that will enable child and adolescent mental health clinicians to better serve diverse children, adolescents, and their families

Target Population

Culturally diverse children and youth younger than 18 years

Interventions and Practices Considered

1. Identification and management of barriers (economic, geographic, insurance, cultural beliefs, stigma, etc.) to mental health services
2. Evaluations conducted in the language in which child/family are proficient
3. Consideration of the impact of dual-language competence on the child's adaptation and functioning
4. Consideration of cultural biases that might interfere with clinical judgment
5. Application of clinician knowledge of cultural differences in developmental progression, idiomatic expressions of distress, and symptomatic presentation
6. Assessment of history of immigration-related loss or trauma and community trauma
7. Evaluation of the acculturation level and presence of acculturation stress and intergenerational acculturation family conflict
8. Inclusion of family members/key members of traditional extended families
9. Evaluation and incorporation of cultural strengths in treatment interventions
10. Treatment of culturally diverse children/families in familiar settings within their communities
11. Development of appropriate parental behavioral management skills consonant with cultural values/beliefs
12. Use of evidence-based psychological and pharmacologic interventions specific for the ethnic/racial population of the child and family
13. Identification of ethnopharmacologic factors (pharmacogenomic, dietary, use of herbal cures)

Major Outcomes Considered

- Barriers (economic, geographic, insurance, cultural beliefs, biases, stigma, language, etc.) that may prevent culturally diverse children and their families from obtaining mental health services
- Risk for misdiagnosis, inadequate treatment, and adverse clinical outcomes

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

In PubMed, the Medical Subject Heading (MeSH) terms *culture*, *Hispanic*, *Latino*, *African American*, *Asian American*, *American Indian*, *child psychiatry*, *child psychology*, *adolescent psychiatry*, *adolescent psychology* and *United States* were searched. The initial search yielded 2,970 results. Then, the results were limited to *English*, *human*, *all child (0 to 18 years)*, and *1990 through December 2011*. Additional limits included *classical article*, *clinical trial*, *comparative study*, *controlled clinical trial*, *evaluation studies*, *guideline*, *historical article*, *meta-analysis*, *practice guideline*, *multicenter study*, *randomized controlled trial*, *review*, *twin study*, and *validation studies*. The refined PubMed search yielded 2,268 articles.

In the PsycINFO database subject headings (focused), the keywords *culture*, *Latino*, *Hispanic*, *African American*, *Asian American*, *American Indian*, and *mental health* were searched. The initial search returned 40,167 articles and then was limited to *English*, articles in the *United States*, *childhood: birth to age 12 yrs*, *adolescence: age 13-17 yrs*, *peer reviewed journal*, and *1990 through December 2011*. The refined PsycINFO search yielded 2,240 articles.

In the *Cochrane Database of Systematic Reviews*, keywords of *culture* and *mental health* were searched without additional limits. The Cochrane search yielded 80 articles. An additional 953 articles were retrieved from the CINAHL database, after excluding MEDLINE articles, by searching *culture*, *Latino*, *Hispanic*, *African American*, *Asian American*, *American Indian*, *mental health*, and *United States* and limiting to *childhood and adolescence*, *peer-reviewed articles*, *English language*, and *1990 through December 2011*.

A total of 5,461 articles were identified. After removing duplicate references, the resulting yield from the comprehensive search was 4,391 articles. The titles and abstracts of all articles were reviewed. Studies were selected for full-text review based on their place in the hierarchy of evidence (e.g., randomized controlled trials), quality of individual studies, and generalizability to clinical practice. The search was augmented by a review of articles nominated by expert reviewers and further search of article reference lists and relevant textbook chapters.

Number of Source Documents

A total of 163 articles were selected for full-text examination.

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus

Rating Scheme for the Strength of the Evidence

Not applicable

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameters are developed by the AACAP Committee on Quality Issues (CQI) in accordance with American Medical Association policy. Parameter development is an iterative process among the primary author(s), the CQI, topic experts, and representatives from multiple constituent groups, including AACAP membership, relevant AACAP committees, the AACAP Assembly of Regional Organizations, and the AACAP Council. Details of the Parameter development process can be accessed on the AACAP website. Responsibility for Parameter content and review rests with the author(s), the CQI, the CQI Consensus Group, and the AACAP Council.

AACAP develops patient-oriented and clinician-oriented Practice Parameters. Patient-oriented Parameters provide recommendations to guide clinicians toward best assessment and treatment practices. Recommendations are based on the critical appraisal of empirical evidence (when available) and clinical consensus (when not) and are graded according to the strength of the empirical and clinical support. Clinician-oriented Parameters provide clinicians with the information (stated as principles) needed to develop practice-based skills. Although empirical evidence may be available to support certain principles, principles are based primarily on clinical consensus. This Parameter is a clinician-oriented Parameter.

Principles for this parameter were identified from the consensus of the AACAP Diversity and Culture Committee and informed by the literature review articles and the *Cultural Competence Standards in Managed Mental Health Care for Four Underserved/Underrepresented Racial/Ethnic Populations*.

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

Internal Peer Review

Description of Method of Guideline Validation

This Practice Parameter was reviewed at the Member Forum at the American Academy of Child and Adolescent Psychiatry (AACAP) Annual Meeting in October 2011.

From November 2012 to January 2013, this Parameter was reviewed by a consensus group convened by the Committee on Quality Issues (CQI).

This Practice Parameter was approved by the AACAP Council on April 16, 2013.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is not specifically stated.

Although empirical evidence may be available to support certain principles, principles are based primarily on clinical consensus.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate clinical applications of the principle of cultural competence will enable child and adolescent mental health clinicians to better serve diverse children, adolescents, and their families

Potential Harms

Not stated

Qualifying Statements

Qualifying Statements

American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameters are developed to assist clinicians in psychiatric decision making. These parameters are not intended to define the sole standard of care. As such, the parameters should not be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all the circumstances presented by the patient and his or her family, the diagnostic and treatment options available, and available resources.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Patient Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Pumariaga AJ, Rothe E, Mian A, Carlisle L, Toppelberg C, Harris T, Gogineni RR, Webb S, Smith J, American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter for cultural competence in child and adolescent psychiatric practice. *J Am Acad Child Adolesc Psychiatry*. 2013 Oct;52(10):1101-15. [104 references] [PubMed](#)

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2013 Oct

Guideline Developer(s)

American Academy of Child and Adolescent Psychiatry - Medical Specialty Society

Source(s) of Funding

American Academy of Child and Adolescent Psychiatry

Guideline Committee

American Academy of Child and Adolescent Psychiatry Committee on Quality Issues (CQI)

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Financial Disclosures/Conflicts of Interest

Disclosures: Dr. Pumariega has received research support from Eli Lilly and Company and has participated on an advisory panel on attention-deficit/hyperactivity disorder (ADHD) in Latino children from Shire Pharmaceuticals. Dr. Rothe has or had a leadership position with the American Academy of Psychoanalysis and Dynamic Psychiatry. Dr. Mian has or had a leadership position with the International Association of Child and Adolescent Psychiatry and Allied Professions. Dr. Toppelberg has received research support from the Norwegian Institute of Public Health, the Norwegian Research Council, and the National Institute of Mental Health; he also has participated on an advisory panel on ADHD in Latino children from Shire Pharmaceuticals. Dr. Harris has or had leadership roles with the Association for Academic Psychiatry, Black Psychiatrists of America, Association of American Medical Colleges, and the American Psychiatric Association. Dr. Gogineni has or had a leadership position with the American Association for Social Psychiatry. Drs. Carlisle, Webb, and Smith have no leadership or financial conflicts to disclose. Dr. Bukstein has or had a leadership role with the American Psychiatric Association, has intellectual property with Routledge Press, and serves or has served as an advisor/consultant to Ezra Innovations. Dr. Walter has no leadership or financial conflicts to disclose. Disclosures of potential conflicts of interest for all other individuals named above are provided on the American Academy of Child and Adolescent Psychiatry (AACAP) website on the [Practice Parameters page](#) .

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available from the [American Academy of Adolescent and Child Psychiatry \(AACAP\) Web site](#) .

Availability of Companion Documents

None available

Patient Resources

The following is available:

- Finding mental healthcare for children of immigrants. Facts for families. Washington (DC): American Academy of Child and Adolescent Psychiatry; 2013 Dec. Available from the [American Academy of Adolescent and Child Psychiatry \(AACAP\) Web site](#) .

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